



Arizona Medical Board

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258

Home Page: <http://www.azmd.gov>

Telephone (480) 551-2700 • Fax (480) 551-2704 • In-State Toll Free (877) 255-2212

FINAL MINUTES FOR BOARD MEETING Held at 9:00 a.m. on November 3, 2006, 9535 E. Doubletree Ranch Road • Scottsdale, Arizona

Board Members

Robert P. Goldfarb, M.D., F.A.C.S., Chair

William R. Martin III, M.D., Vice Chair

Douglas D. Lee, M.D., Secretary

Patrick N. Connell, M.D.

Patricia Griffen

Tim. B. Hunter, M.D.

Becky Jordan

Ram R. Krishna, M.D.

Lorraine L. Mackstaller, M.D.

Sharon B. Megdal, Ph.D.

Dona Pardo, Ph.D., R.N.

Paul M. Petelin Sr., M.D.

Friday, November 3, 2006

CALL TO ORDER

Robert P. Goldfarb, M.D. called the meeting to order at 9:00 a.m.

ROLL CALL

Roll call was taken and the following members were present: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N. and Paul M. Petelin, Sr., M.D. The following member was absent: Tim B. Hunter, M.D.

CALL TO PUBLIC

Dean Brekke, Assistant Attorney General introduced Assistant Attorney General Emma Mamaluy who has joined the Licensing and Enforcement Section and elaborated on her credentials.

Additional statements issued during the call to the public appear beneath the case referenced.

NON-TIME SPECIFIC ITEM

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-93-1096	AMB	ROBERT KERSHNER, MD	4390	Deny the request for Termination of Board Order.

Ms. Chris Banyas, Assistant Manager, Monitoring Office summarized the case for the Board. Robert Kershner, M.D. requested the Board terminate his October 26, 1998 Stipulation and Order restricting him from performing functional cosmetic surgery of the brow, eyebrow, ptosis and/or blepharochalsis. Dr. Kershner had not presented evidence to the Board to show he was sufficiently rehabilitated in order to support his request for termination of his Board Order. Ms. Banyas noted, although Dr. Kershner signed a sworn statement that he would not perform the types of procedures the Board restricted him from at anytime in the future, if the Board lifted his practice restriction there would be no way to monitor or prevent Dr. Kershner from performing such procedures. Dr. Kershner made this request after informing Board Staff the Board's Order is preventing him from getting a license in Florida.

Paul M. Petelin, Sr., M.D. noted Dr. Kershner claimed his restricted medical license in Arizona precluded him from qualifying for a medical license in the state of Florida and asked Staff if this was a true statement because he noted Dr. Kershner had active licenses in two separate states and his restriction did not preclude him from receiving a license. Ms. Banyas said the Minutes from the Florida State Board meeting showed the Florida Board intended to consider the issue at its December meeting and it is not clear if the Arizona restriction is an absolute bar to his receiving a Florida medical license.

Sharon B. Megdal, Ph.D. asked the Board to consider if they would be protecting the public by lifting the Board Order, seeing as how Dr. Kershner had not proved his remediation. Dr. Megdal noted the Board's Order would not keep Dr. Kershner from employment as he had a license in two other states.

MOTION: Douglas D. Lee, M.D. moved to deny the request for termination of Board Order.

SECONDED: Ram R. Krishna, M.D.

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent

MOTION PASSED.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-1162A	AMB	DWIGHT KELLER, M.D.	14555	Issue an Advisory Letter for not timely recognizing a post-operative complication. This was a technical violation.

Dwight Keller, M.D. was present with counsel Mr. Daniel Jantsch.

William R. Martin, III, M.D. said both he and Dr. Keller were part of a panel of physicians for Orthopedic Surgeons Network of Arizona. However, Dr. Martin said he did not socialize with Dr. Keller and their positions together on the panel would not affect his ability to adjudicate the case. Ram R. Krishna, M.D. and Paul M. Petelin, Sr., M.D. said they knew Mr. Jantsch, but it would not affect their ability to adjudicate the case.

Gerald Moczynski, M.D., Medical Consultant summarized the case for the Board. A medical malpractice settlement on behalf of Dr. Keller alleged he negligently applied cerclage wires during a surgery leading to vascular compromise. The patient also alleged Dr. Keller's delay in recognition of vascular compromise led to an inability to achieve union of the fracture and ultimately ended in above the knee amputation. Dr. Moczynski noted Dr. Keller did not document the patient's pulses either pre-operatively or post-operatively. The patient experienced increasing pain as noted by the nurses, however, it was mitigating that the nurses did not notify Dr. Keller of the patient's condition. Dr. Moczynski stated he was unable to support a direct correlation between the surgery performed by Dr. Keller and the patient's above the knee amputation two years later.

Mr. Jantsch noted the Staff Interim Review Committee (SIRC) report spoke of non-delegable duty and he stated that was not a proper legal doctrine to apply in this case. Mr. Jantsch asked the Board to consider his statement during their deliberations.

William R. Martin, III, M.D. led the questioning. Dr. Martin found the patient was experiencing pain because there was a non-union of the bone and the standard of care would have been to use a bone stimulator to speed up the healing process prior to surgery. Dr. Martin noted Dr. Keller's records did not show he had orders for a bone stimulator, or that he spoke to the patient regarding the option of the bone stimulator prior to surgical intervention.

Dr. Martin noted that, following surgery, Dr. Keller did not palpate the patient's pulses or did not look at the patient's capillary refill. Dr. Keller said the nurses had orders to check the patient's neurovascular status, but they did not do it. Dr. Keller admitted he did not personally feel the patient's post-operative pulses.

Ram R. Krishna, M.D. noted Dr. Keller relied heavily on his physician assistant for making post-operative rounds. Dr. Krishna noted Dr. Keller stated he was never notified of any change in the patient's neuromuscular or neurovascular status of the patient and Dr. Keller did not give any specific orders to nursing staff to look for neurovascular compromise other than that he had worked with the same nurses for 16 years and it was an understood order.

Dr. Goldfarb noted the first time Dr. Keller was told there were problems with the patient was not until 15 hours after surgery, however, Dr. Keller could have, but did not take the initiative to call in and check on the patient himself.

Dr. Petelin noted there was a point when Dr. Keller was aware that his colleague went in to re-vascularize the patient's leg and he should have gone to see the patient at that point because if there was a complication with his surgery he should have been there to address and correct the problem.

Dr. Keller said he did not believe it was below the standard of care to fail to use a bone stimulator prior to surgery, although he would have usually used one himself. Dr. Keller said he could not remember if he used a bone stimulator in this case. Dr. Keller said that, following surgery, he appropriately delegated checking the patient's pulses to nursing staff and was appalled he was not immediately notified of the patient's worsening condition. Dr. Keller said he did not feel it was necessary to present with Dr. Walker to re-vascularize the patient's leg because the patient was in the hands of another orthopedic surgeon who had the same interest in her care that he did. Dr. Keller said he did not believe it was the standard of care to check the pulses himself, but rather the standard in the community is to rely on the nursing staff to follow up on such.

Mr. Jantsch said nursing staff must be relied on in a physician's practice. Mr. Jantsch stated the application of the cerclage wire on the artery, in and of itself, was not below the standard of care.

Dr. Martin said he realized that from Dr. Keller's standpoint this was an extremely difficult case. Dr. Martin noted the patient had been operated on multiple times, had a lot of scar tissue, and the placement of the cerclage wire was a blind placement. Dr. Martin found that the complication of placing the cerclage wire was not below the standard of care. However, he did find it was below the standard of care that Dr. Keller did not recognize the surgical complication earlier. Dr. Martin stated Dr. Keller should have looked for complications post operatively knowing this was a

potentially complicated case and should not have relied on the nurses. Dr. Martin said based on the Medical Consultant's comments and his personal knowledge, it is the standard of care for a physician to personally assess a patient after a major surgery.

Dr. Martin found there was actual harm, but it was not related to the above the knee amputation. Dr. Martin did not find the patient's subsequent amputation to be related to Dr. Keller's procedure. Dr. Martin said the actual harm was that the patient had to undergo a second surgery as a result of Dr. Keller's technique.

MOTION: William R. Martin, III, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(II)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.

SECONDED: Patrick N. Connell, M.D.

VOTE: 9-yay, 2-nay, 0-abstain, 0-recuse, 1-absent

MOTION PASSED.

Dr. Martin said there were a number of mitigating circumstances in this case, such as the lack of communication from the nursing staff. Dr. Martin stated this case constituted a technical violation and did not rise to the level of a disciplinary action.

MOTION: William R. Martin, III, M.D. moved to issue an Advisory Letter for not timely recognizing a post-operative complication. This was a technical violation.

SECONDED: Patrick N. Connell, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following member was absent: Tim B. Hunter, M.D.

VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent

MOTION PASSED.

Douglas D. Lee, M.D. asked Staff to look into the care rendered by the anesthesiologist in this case. Dona Pardo, Ph.D., R.N. asked Staff to refer this to the Arizona State Board of Nursing.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	RESOLUTION
2.	MD-05-0834A	AMB RORY N. MINCK, M.D.	11912	Dismiss.

Rob Newman, M.D. spoke during the call to the public and testified that he found Dr. Minck's actions in this case to be within the standard of care and that even if Dr. Minck had sat at the patient's bedside constantly the outcome of the patient could not have been changed. Dr. Newman stated five expert perinatologist witnesses also came to the same conclusion in this case.

Gordon Davis, M.D. also spoke in favor of Dr. Minck during the call to the public. Dr. Davis stated he has followed Dr. Minck's work and career and found him to be a competent and caring physician. Dr. Davis said that in his dealings with preeclamptic patients, those who did and did not survive preeclampsia were treated in the same manner, yet had different results. Dr. Davis said the way in which the Internal Medical Consultant analyzed this case showed a difference in residency training opinions, however, Dr. Minck handled this case in the most appropriate manner.

Rory Minck, M.D. was present with counsel Mr. Daniel Jantsch. Ram R. Krishna, M.D. and Paul M. Petelin, Sr., M.D. said they knew Mr. Jantsch but it would not affect their ability to adjudicate the case.

Ingrid Haas, M.D., Medical Consultant presented the case to the Board. A medical malpractice settlement alleged Dr. Minck failed to appreciate the severity of the condition of a patient who presented in labor with severe preeclampsia/Hemolysis, Elevated Liver functions, Low Platelet (HELLP) syndrome, who later died. The Staff Investigational Review Committee (SIRC) found Dr. Minck appropriately managed the patient's preeclampsia and HELLP syndrome. However, SIRC questioned if it was appropriate that Dr. Minck did not come in to evaluate the patient prior to the time when C-Section was required.

William R. Martin, III, M.D. led the questioning. Dr. Martin noted the patient needed immediate attention according to her vital signs. However, Dr. Minck did not evaluate the patient physically over a five hour period and did not see the patient until it was time for her to be taken into the operating room for C-section. Dr. Martin noted, upon the patient's admission, Dr. Minck should have made the diagnosis of preeclampsia based on her vital signs told to him by the nurses. Dr. Minck said the patient was new to him and he did not act immediately on a differential of preeclampsia because he was trying to gather information in order to make a definitive diagnosis for the patient. Dr. Minck said the patient was stable despite the diagnosis and was not critically ill. Dr. Minck said the patient's blood pressures had stabilized and she appeared to be improving. Dr. Minck said this was a precedent case, not noted in literature, where a patient had stable vital signs, but subsequently died from preeclampsia. Dr. Minck said if he had to repeat the events of this case he would have been at bedside of the patient to physically evaluate her. However, Dr. Minck said that even if he would have been at the patient's bedside he could not have done anything different for her treatment and her outcome would not have changed. Dr. Minck said he followed the standard of care for this patient.

Robert P. Goldfarb, M.D. noted the fact this patient was new to Dr. Minck made it more necessary for him to do a hands on evaluation. Dr. Minck said he has changed his practice now to do a hands-on examination wherever he diagnoses HELLP syndrome. Dr. Goldfarb found Dr. Minck fell below the standard of care by relying on the nurses entirely and by not appearing to see the patient until brain hemorrhaging had begun. Lorraine Mackstaller, M.D. noted Dr. Minck did not order a preeclamptic workup for the patient until he received a prompt from a nurse to do so. Douglas D. Lee, M.D. noted that if Dr. Minck would have physically examined the patient, the outcome may not have changed but it may have speed up treatment for the patient.

Mr. Jantsch said, although it is optimal to be at a patient's bedside, it is not the standard of care, and is impossible for physicians to be at the bedside of each patient.

Dr. Martin noted SIRC found Dr. Minck's care was appropriate and the only deviation was that he was not at the patient's bedside to evaluate her. Dr. Martin said he did not see that the patient's outcome would have changed if Dr. Minck would have been at her bedside.

MOTION: William R. Martin, III, M.D. moved to Dismiss the case.

SECONDED: Patricia R.J. Griffen

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N. and Paul M. Petelin, Sr., M.D. The following members voted against the motion: Patrick N. Connell, M.D., Ram R. Krishna, M.D. and Douglas D. Lee, M.D. The following member was absent: Tim B. Hunter, M.D.

VOTE: 8-yay, 3-nay, 0-abstain, 0-recuse, 1-absent

MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-05-0828A	AMB	PHILIP A. BAKER, M.D.	31466	Issue an Advisory Letter for incomplete evaluation of a febrile patient with a severe headache.

Philip Baker, M.D. was present with counsel Mr. Gordon Clevenger.

Kelly Sems, M.D., Internal Medical Consultant summarized the case for the Board. A medical malpractice settlement alleged Dr. Baker failed to diagnose and treat pneumonia resulting in the death of a patient. The Outside Medical Consultant (OMC) found Dr. Baker deviated from the standard by failing to perform a thorough evaluation of the patient by failing to perform a chest x-ray, failing to perform a pulse oximeter reading, and failing to administer a dose of intravenous (IV) antibiotics. Additionally, Dr. Baker failed to re-check the patient's vital signs or reassess him prior to discharge.

Patrick N. Connell, M.D. led the questioning and noted the nurses found the patient was wheezing, but Dr. Baker did not address that finding. Dr. Baker said he did not hear wheezing in the patient, but thought if the nurses did hear occasionally wheezing, it could be because the patient was a smoker. Dr. Connell noted the patient had a fever, severe headache, tachycardia and leukocytosis with a left shift and these findings should have alerted Dr. Baker to the diagnosis of pneumonia. Dr. Connell also found Dr. Baker should have performed a lumbar puncture, and should have further investigated a diagnosis of meningitis. Paul M. Petelin, Sr., M.D. said the fact the patient was a two-pack per day smoker, should have alerted Dr. Baker to think of other etiologies.

Dr. Baker said there were mitigating circumstances in this case in that he did not hear any wheezing sounds when he examined the patient and the patient was insistent that his only symptom was his headache. Dr. Baker felt these facts may have lead him down the wrong path for the patient's diagnosis. Dr. Baker noted that, in hindsight, he could have done things differently, such as obtaining a lumbar puncture. Dr. Baker said he is now a practicing radiologist and will not be going back to emergency room work in the future.

Dr. Connell noted Dr. Baker agreed he failed to address the nursing note that may have led him in a different direction, failed to get pulse oximetry and failed to aggressively pursue a patient with fever, severe headache and leukocytosis. Dr. Connell noted Dr. Baker also misinterpreted the patient's CT scan. At the time Dr. Baker read the CT scan he had not completed his radiology residency. However, Dr. Connell found Dr. Baker's departure from standard of care did not rise to the level of a disciplinary action.

MOTION: Patrick N. Connell, M.D. moved to Issue an Advisory Letter for incomplete evaluation of a febrile patient with a severe headache.

SECONDED: Paul M. Petelin, Sr., M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N. and Paul M. Petelin, Sr., M.D. The following member was absent: Tim B. Hunter, M.D.

VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent

MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-05-0866A	AMB	TIMOTHY J. GELETY, M.D.	21851	Draft Finding of Fact, Conclusions of Law and Order for a Letter of Reprimand for not evaluating a patient postoperatively and for not being available in a timely fashion following surgery for a patient.

Timothy Gelety, M.D. was present with counsel Ms. Heather Hendrix.

Robert P. Goldfarb, M.D. asked the Board if they had any bias for or against Ingrid Haas, M.D., Medical Consultant since she was a prior Board Member. The Board Members stated they had no bias for or against Ingrid Haas, M.D., Medical Consultant.

Ingrid Haas, M.D., Medical Consultant summarized the case to the Board. A hospital reported a suspension of Dr. Gelety's privileges due to three cases, patient KK, AD and YS. The Medical Consultant found Dr. Gelety deviated from the standard of care for patient KK by failing to adequately monitor KK's fluid status following a hysteroscopy before proceeding with a laparoscopy. Dr. Gelety did not obtain KK's sodium level until the end of the laparoscopic procedure. The Medical Consultant found Dr. Gelety deviated from the standard of care for patient AD by failing

to see her until 24 hours after her admission to the hospital. Dr. Gelety also delayed AD's surgical evaluation despite AD's abdominal/pelvic CT indicating probable abscess formation in a patient with ongoing fevers. In patient YS, the Medical Consultant found Dr. Gelety was not available immediately following YS's surgery and numerous attempts to contact him for six hours were unsuccessful.

Douglas D. Lee, M.D. led the questioning. Dr. Lee found there was a large amount of fluid absorption in patient KK. However, Dr. Lee noted the size of KK's lesion could have contributed to the large absorption of fluids.

Dr. Lee noted for patient AD, Dr. Gelety should have been more timely in seeing the patient and fell below the standard of care by not doing so. Dr. Lee noted Dr. Gelety also delayed surgical consultation by waiting three days to obtain a surgical consult although Dr. Gelety admitted he could not rule out bowel perforation. Paul M. Petelin, Sr., M.D. noted if Dr. Gelety would have come in sooner to examine AD, it would have raised his level of concern and AD would have received treatment sooner.

Dr. Lee noted, for patient YS, Dr. Gelety said he was not on call and turned off his cell phone following YS's surgery. Dr. Lee found Dr. Gelety failed to give staff specific instructions that he was not on call and who they may contact with concerns.

Dr. Gelety said these three cases were found to be within the standard of care by the hospital peer review. Dr. Gelety said, after these cases were referred to the Board, the hospital reinstated his privileges and he is now facing a possible election for the head of the Obstetrics and Gynecology Department. Dr. Gelety said, for patient AD, he immediately obtained a CT scan when AD first presented and the radiologist thought there was no bowel perforation. Dr. Gelety said he delayed surgical evaluation because he did not want to cause a bowel perforation if there was not one already there. Dr. Gelety said, for patient YS, he was not on call, but his nurse is always readily available and can contact him. Dr. Gelety said hospital staff should have contacted him at the number at which his nurse could be reached and could have obtained that number by contacting the main line at the hospital.

Dr. Lee said he did not find a deviation in the case of patient KK as the amount of fluid absorbed was probably not excessive considering the size of the tumor present. Dr. Lee said his concern in the case of AD was Dr. Gelety's lack of timeliness. Dr. Lee noted Dr. Gelety wrote orders late for AD, did not immediately evaluate AD and delayed AD's surgical consultation, subsequent evaluation and treatment. Dr. Lee found that in the case of YS, the burden was on Dr. Gelety to let staff know he was not going to be on-call and what physician was going to be available for staff to contact.

MOTION: Douglas D. Lee, M.D. moved for a finding of Unprofessional Conduct for patient AD in violation of A.R.S. §32-1401 (27)(II)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient and Unprofessional Conduct for patient YS in violation of A.R.S. §32-1401(27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.

SECONDED: Patrick N. Connell, M.D.

Sharon B. Megdal, Ph.D. abstained from the case stating she did not see any communication regarding Dr. Gelety's privileges being reinstated at the hospital.

VOTE: 10-yay, 0-nay, 1-abstain, 0-recuse, 1-absent

MOTION PASSED.

MOTION: Douglas D. Lee, M.D. moved to Draft Finding of Fact, Conclusions of Law and Order for a Letter of Reprimand for not evaluating patient AD postoperatively and for not being available in a timely fashion following surgery for patient YS.

SECONDED: Ram R. Krishna, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D. and Paul M. Petelin, Sr., M.D. The following Board Member voted against the motion: Lorraine Mackstaller, M.D. The following Board Members abstained: Robert P. Goldfarb, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N. The following Board Member was absent: Tim B. Hunter, M.D.

VOTE: 6-yay, 1-nay, 4-abstain, 0-recuse, 1-absent

MOTION PASSED.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	RESOLUTION
5.	MD-06-0081A	T.B. DANIEL T. FANG, M.D.	30861	Issue an Advisory Letter for failure to follow up on an indeterminate chest x-ray prior to elective surgery.

Patient TB was present and her husband read her statement to the Board during the call to the public. TB was concerned Dr. Fang did not inform her of a finding of lung nodules prior to her elective surgery. If Dr. Fang told her she had tuberculosis she would not have proceeded with the elective gastric bypass procedure. TB said her life hangs in the balance as she is unsure if she will be able to continue on the antibiotic cocktail she is currently on because of how the body eventually becomes resistant to various antibiotics. TB stated she has been on antibiotics for 10 months now and has become resistant to the medications. TB stated if she is taken off the medications she will die from the tuberculosis.

Daniel Fang, M.D. was present with counsel Mr. Stephen Myers.

Kelly Sems, M.D., Internal Medical Consultant summarized the case for the Board. Dr. Sems said Dr. Fang said he informed TB of her lung nodules prior to surgery, however, there was no documentation of this discussion in the medical record and TB stated she was notified months after her elective surgery.

Vicki Johansen, Senior Medical Investigator summarized the unprofessional conduct issues of the case. Ms. Johansen said Dr. Fang claimed he faxed TB's x-ray results to her primary care physician, Carol Mimless, M.D. prior to her surgery. However, Staff verified with Dr. Mimless' office that they had not received a faxed report from Dr. Fang's office.

Paul M. Petelin, Sr., M.D. led the questioning. Dr. Fang said the radiologist was not concerned initially with the lung nodules. However, he later recommended Dr. Fang either obtain a prior x-ray for the patient or perform a follow up x-ray. Dr. Petelin noted there were two chest x-rays Dr. Fang could have obtained from Dr. Mimless that would have shown that an x-ray two years prior and a second x-ray eight months prior were both normal. Dr. Petelin said this would have shown that the most recent x-ray by Dr. Fang demonstrated new nodules in the patient's lungs. Dr. Petelin noted Dr. Fang said he informed TB of the findings and she elected to proceed with the gastric bypass. Dr. Petelin stated it was below the standard of care to give the patient the choice to proceed with an elective surgery as the responsibility is on the physician to know when a procedure is or is not appropriate. Dr. Petelin found the gastric bypass procedure should not have been performed for this patient with tuberculosis.

Dr. Fang said the patient was not acutely ill, was morbidly obese and met the criteria for bariatric surgery. Dr. Fang said he intended the x-ray results to be faxed to the patient's primary care physician and left his staff with the responsibility to do so, after he filled out the fax coversheet and marked the pages that needed to be sent. Dr. Fang said he relied on his staff to send the information to Dr. Mimless and was not aware it was not sent until Board Staff made him aware. Dr. Fang said he was shocked that, because a clerical error occurred, the Board jumped to the conclusion that he lied.

Mr. Myers noted Board Staff seemed concerned about Dr. Fang's handling of the lung x-ray, but did not seem bothered that the radiologist in this case was not initially concerned about the findings. Mr. Myers stated Dr. Fang notified patient TB about the results of the x-ray over the phone, but as in any medical record, it is a rare occurrence that telephone conversations are documented. Mr. Myers said the lack of documentation did not mean the phone conversation did not occur.

Dr. Petelin noted there was no documentation of an abnormal chest x-ray finding by Dr. Fang or the physician assistant in the entire St. Luke's Hospital medical file either in the hospital notes or in the discharge summary following the surgery. Dr. Petelin also noted the standard of care required Dr. Fang to use the patient's history, physical and x-ray to determine it was not safe to proceed with elective procedure. Dr. Petelin also said he found Dr. Fang's testimony not credible that he informed the patient and attempted to inform the patient's primary care physician of the x-ray findings. Dr. Petelin said he did not find sufficient evidence to support disciplinary action although he did find the following statutes were violated: A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public and A.R.S. §32-1401 (27)(jj) - Knowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board.

MOTION: Paul M. Petelin, Sr., M.D. moved to issue an Advisory Letter for failure to act on an abnormal chest x-ray prior to surgery and for making a false or misleading statement to the Board. Obtain 15 hours of non-disciplinary CME in Ethics.

SECONDED: Lorraine Mackstaller, M.D.

Douglas D. Lee, M.D. said he did not support that Dr. Fang had made a misleading statement to the Board because he found his explanation to be credible that the intended fax did not go through. Robert P. Goldfarb, M.D. stated although the fax may not have gone through, Dr. Fang should have spoken to the primary care physician prior to surgery.

William R. Martin, III, M.D. said, although he was disappointed more attempts were not made to communicate with the primary care physician, the fax was attempted to be sent. Dr. Martin said he supported the first part of the motion, but not the part regarding lying to the Board. Dona Pardo, Ph.D., R.N. also said she had trouble supporting that Dr. Fang had lied to the Board.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Lorraine Mackstaller, M.D. and Paul M. Petelin, Sr., M.D. The following members voted against the motion: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. The following member was not present: Tim B. Hunter, M.D.

VOTE: 3-yay, 8-nay, 0-abstain, 0-recuse, 1-absent

MOTION FAILED.

MOTION: Sharon B. Megdal, Ph.D. moved to issue an Advisory Letter for failure to follow up on an indeterminate chest x-ray prior to elective surgery.

SECONDED: Dona Pardo, Ph.D., R.N.

Dr. Goldfarb spoke against the motion stating this case went beyond an Advisory Letter. Dr. Goldfarb said he was troubled Dr. Fang undertook a very large procedure with significant risks without fully evaluating the patient preoperatively and without discussing the abnormal findings with the primary care physician preoperatively. Ram R. Krishna, M.D. and Patricia R.J. Griffen spoke against the motion stating the case warranted more than an Advisory Letter.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Becky Jordan, Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D. and William R. Martin, III, M.D. The following Board Member was absent: Tim B. Hunter, M.D.

VOTE: 6-yay, 5-nay, 0-abstain, 0-recuse, 1-absent

MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-05-0428B	AMB	JOHN R. TESSER, M.D.	11285	Issue an Advisory Letter for failure to properly supervise a physician assistant.

John Tesser, M.D. was present with counsel Mr. Kraig Marton.

William R. Martin, III, M.D. stated he referred patients to Dr. Tesser, but it would not affect his ability to adjudicate the case. Kelly Sems, M.D., Internal Medical Consultant said she also knew Dr. Tesser, but it did not affect her ability to be involved in the case.

Kelly Sems, M.D., Internal Medical Consultant summarized the case for the Board. A medical malpractice settlement alleged Dr. Tesser negligently supervised his physician assistant (PA) who prescribed non-steroidal anti-inflammatory drugs (NSAIDs) to a known diabetic patient, resulting in acceleration of end-stage renal disease. Dr. Sems noted there was no evaluation of the patient's 2+ through 4+ pitting edema, hypertension, hypoalbuminemia and significant proteinuria (nephrotic syndrome) until one year after a documentation of the significant proteinuria. The Staff Investigational Review Committee (SIRC) found actual harm in Dr. Tesser's failure to recognize, diagnose and evaluate the patient's nephrotic syndrome until one year after the onset of the findings. This led to a delay in diagnosis and the patient went on to have renal failure and hemodialysis. SIRC found potential harm in that the medication Diclofenac was not recognized as a potential aggravator or cause of the patient's deteriorating condition.

Robert P. Goldfarb, M.D. led the questioning. Dr. Goldfarb noted Dr. Tesser's statement that his counter signature on the notes reflected he had reviewed the PA's notes. Dr. Goldfarb noted there were some notes that were not reviewed. Dr. Tesser said during the course of the treatment he was satisfied they were doing all they could with the patient. Dr. Goldfarb did not see any independent recommendations from Dr. Tesser to the PA, so one could assume he was in agreement with the PA's treatment.

Dr. Goldfarb noted it was very rare that she had 3+ to 4+ edema from the ankles to buttocks. Dr. Goldfarb noted the medical record made it appear arthritis was the primary reason for edema and found it disconcerting that arthritis appeared to be the number one reason the medical records noted for the cause of edema.

Dr. Tesser said it was not well documented that there were other factors contributing to the patient's edema. Dr. Tesser said the patient also had diabetes and nephrotic syndrome and the natural course of the disease would be to develop renal failure. Dr. Tesser said the patient's arthritis was difficult to control, requiring five different inflammation drugs, before prescribing the Diclofenac.

Mr. Marton said Dr. Tesser was not the only one who continued the use of the Diclofenac for the patient as there were two other nephrologists and two other primary care physicians who continued prescribe Diclofenac for the patient as well.

Dr. Goldfarb said it appeared Dr. Tesser's physician assistant was on auto-pilot with the care of the patient as there were notes that were and were not countersigned by Tesser. Dr. Goldfarb said Dr. Tesser should have intervened in the patient's care when he saw the multiple notes of the 3+ and 4+ edema. Dr. Goldfarb found Dr. Tesser failed to recognize and evaluate the nephrotic syndrome in this patient, for over a year, and also maintained inadequate supervision of his physician assistant.

MOTION: Robert P. Goldfarb, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(ii) - Lack of or inappropriate direction, collaboration or direct supervision of a medical assistant or a licensed, certified or registered health care provider employed by, supervised by or assigned to the physician.

SECONDED: Ram R. Krishna, M.D.

VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent

MOTION PASSED.

Lorraine Mackstaller, M.D. said she was concerned with the use of NSAIDS in this case as they are not as benign as one would think.

MOTION: Robert P. Goldfarb, M.D. moved to instruct Staff to draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to properly supervise a physician assistant.

Sharon B. Megdal, Ph.D. and Paul M. Petelin, Sr., M.D. spoke against the motion stating they were in favor of an Advisory Letter.

Dr. Mackstaller said the patient's diabetes was uncontrolled and there were many mitigating factors as the patient appeared to be non-compliant. Dr. Mackstaller noted the patient's diabetes would cause renal failure and the prescribing of NSAIDS made it worse.

Ram R. Krishna, M.D. found there was patient harm in this case that Dr. Tesser was partially responsible for. Dr. Megdal noted this was a first time occurrence and a technical error.

Dr. Goldfarb found the issue in this case to be that Dr. Tesser's failed to supervise his physician assistant for 14 patient visits. Dr. Mackstaller said she found the issue in this case to be that the patient's primary care physician had the responsibility to coordinate the patient's care and did not do so.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., and William R. Martin, III, M.D. The following Board Members voted against the motion: Patrick N. Connell, M.D., Patricia R.J. Griffen, Becky Jordan, Lorraine Mackstaller, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N. and Paul M. Petelin, Sr., M.D. The following Board Members was absent: Tim B. Hunter, M.D.
VOTE: 4-yay, 7-nay, 0-abstain, 0-recuse, 1-absent
MOTION FAILED.

MOTION: Sharon B. Megdal, Ph.D. moved to issue an Advisory Letter for failure to properly supervise a physician assistant.
SECONDED: Patrick N. Connell, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N. and Paul M. Petelin, Sr., M.D. The following Board Member voted against the motion: Ram R. Krishna, M.D. The following Board Member was absent: Tim B. Hunter, M.D.
VOTE: 10-yay, 1-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC. #	RESOLUTION
7.	MD-05-0175A	AMB M. AZAM KHAN, M.D.	9994	Refer to Formal Hearing.

Azam Khan, M.D. was present with counsel Mr. Ed Hendricks Sr.

Paul M. Petelin, Sr., M.D. said he knows Mr. Hendricks, but it would not affect his ability to adjudicate the case.

Mark Nanney, M.D., Chief Medical Consultant summarized the case for the Board. Dr. Nanney said SIRC reviewed the case based on a hospital action taken regarding an Emergency Medical Treatment and Active Labor Act (EMTALA) violation. The Internal Medical Consultant (IMC) found Dr. Khan fell below the standard of care as an on-call physician when he failed to respond to two requests from the emergency room physician and violated EMTALA rules when failing to perform a prompt appendectomy on a 5-year-old patient diagnosed with acute appendicitis. The Staff Investigational Review Committee (SIRC) noted Dr. Khan's extensive history and recommended Revocation of his Arizona medical license.

The Board went into Executive Session for legal advice at 3:34 p.m.
The Board returned to Open Session at 3:41 p.m.
No deliberations or decisions were made during Executive Session.

Mr. Hendricks said both he and Dr. Khan were not aware of an EMTALA violation in this case.

Patrick N. Connell, M.D. led the questioning and noted when Dr. Khan was given the finding of acute appendicitis he did not give admitting orders for the patient. Dr. Connell noted there was a statement from another physician in the medical record that the patient required urgent surgical intervention. Dr. Khan said that information was never communicated to him. Dr. Connell said the fact Dr. Khan was on call required him to come into the hospital without being specifically told. Dr. Connell noted the standard of care in a five-year-old patient with leukocytosis and appears toxic is to remove the appendicitis immediately.

Douglas D. Lee, M.D. noted the statistics for children under the age of seven who presented with a ruptured appendicitis was 25%, which is high. Dr. Lee said it was not standard of care to delay treatment for the patient in this case.

Ram R. Krishna, M.D. noted, although Dr. Khan said he eventually went in to see the patient, there was no documentation of such in the hospital record.

Dr. Khan said the emergency room physician did not communicate directly with him and when he did present to the hospital eventually, he was prohibited from making an entry in the patient's chart because the patient had been referred to another surgeon. Dr. Khan said he was never cited for an EMTALA violation, he did practice within the standard of care and the only issues in this case were those of communication.

Mr. Hendricks said that even the Board's IMC acknowledged the on call physician cannot make an entry in the emergency room record when another equally qualified physician takes over the patient's care. Therefore, it was acceptable that Dr. Khan did not make documentation of his presentation to the hospital.

Dr. Connell said he found it difficult to believe, Dr. Khan, given his long history with the Board and understanding he was on call, did not present to see the patient. Dr. Connell stated he felt, if Dr. Khan would have presented to the hospital, the nursing notes would have reflected such even if Dr. Khan could not make documentation in the patient's medical record. Dr. Connell said there was no evidence Dr. Khan did present to the hospital. Dr. Connell also noted the Center for Medicaid Services (CMS) found a quality of care violation based on Dr. Khan's actions and Dr. Connell said he also found a quality of care violation in this case.

MOTION: Patrick N. Connell, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Douglas D. Lee, M.D.

The motion was withdrawn.

MOTION: Sharon B. Megdal, Ph.D. moved to refer to Formal Hearing.

SECONDED: Becky Jordan

VOTE: 9-yay, 1-nay, 0-abstain, 0-recuse, 2-absent

MOTION PASSED.

The meeting adjourned at 5:00 p.m.



A handwritten signature in black ink, appearing to read "T. C. Miller".

Timothy C. Miller, J.D., Executive Director